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Enhancing the Well-Being of Young Children and Families in the Context of Welfare Reform

Lessons from Early Childhood, TANF, and Family Support Programs

Roughly two-thirds of the recipients of federally-subsidized cash assistance are children, nearly half of whom are under age six. Research suggests that young children who grow up in families with limited incomes face potential exposure to multiple environmental and biological risk factors. The research also provides evidence that for those not doing well, child development and family support programs, which emphasize early learning and promote healthy parent-child and child-caregiver relationships, can make a difference.

This report presents findings about emerging approaches to enhance the well-being of young children and families in the context of welfare reform. It explores a variety of efforts to meet the needs of young children and families and profiles 11 programs and initiatives, including stand-alone early childhood programs, Early Head Start sites, welfare agencies, statewide initiatives, and state and local partnerships between early childhood and welfare programs. The project is a partnership between the National Center for Children in Poverty and Mathematica Policy Research.

The researchers sought to answer three questions: How are child development and family support programs serving low-income families with young children responding to new welfare policies and practices? What kinds of partnerships (e.g., state-local, public-private, interagency) are developing between those serving low-income families with young children and those implementing welfare changes? What opportunities and challenges are emerging for early childhood programs and agencies implementing welfare changes as they strive to improve outcomes for both adults/parents and young children? To answer these questions the researchers examined case management strategies, child assessment programs, links between pre-kindergarten and child care programs, school-readiness programs, assistance for families who are coping with domestic violence, substance abuse, and other risk factors, and other workings of these programs.

Recommendations are offered about what early childhood programs and TANF programs can do to strengthen programs, policies, and collaborations to better meet the needs of young children and families affected by the changes in welfare. Suggestions are offered for 1) what early childhood programs can do, such as: Ensure that staff and participating families are knowledgeable about all relevant welfare-related policies and potential resources that might help families; Continue to work to improve the availability of high-quality child care that is responsive to family needs; Develop a support process for families transitioning to work to help them meet the dual demands of work and parenting; Expand outreach strategies to fathers whether or not they live with their children; 2) what TANF and other welfare-related programs can do, for example: Develop formal arrangements at the state and local levels for early childhood programs to carry out tasks related to families' self-sufficiency plans; Train TANF and related staff on a statewide and local basis in family-centered practices; Use TANF interviews and assessments to screen and identify those families for whom intensive ser-

vices are needed and in which young children are likely to be affected adversely by welfare rules, and 3) what Early Childhood, TANF, and other welfare-related programs can do jointly, for example: Team together to develop partnerships at the state and local levels to promote the well-being of children; Develop a shared agenda focused on families with the most severe barriers to work and the needs of young children, and; Promote evaluations of the impact of welfare changes.

This study was conducted by Mathematica Policy Research, Inc. for the Office of the Assistant Secretary for Planning and Evaluation (ASPE). The project officer, Martha Moorehouse, can be reached at 202-690-6939. Copies of the final report, #6754, are available from the PIC.

State Welfare-to-Work Policies for People with Disabilities

Changes Since Welfare Reform

Prior to passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), welfare recipients with disabilities and caregivers were generally exempt from participating in welfare-to-work programs. Cash assistance was also available for an unlimited period. This study sought to determine the extent to which states have changed their policies under PRWORA to emphasize work participation and time limits for receiving cash assistance. This was the first attempt to provide a nationwide overview of new welfare-to-work policies as they affect persons with disabilities and caregivers of family members with disabilities. Temporary Assistance for Needy Families (TANF) plans and other relevant policy documents were reviewed and discussions were held with welfare agency staff in each of the 50 states and the District of Columbia.

The major findings of the report are that a majority of states have changed their work participation policies to require participation among some individuals with disabilities and caregivers who were previously exempt. However, most States are in the early stages of deciding who should be required to participate in welfare-to-work services, who should be expected to move off welfare within 60 months, and what services will best help recipients achieve this objective. One of the major challenges that States face is how to structure appropriate services and service delivery systems for individuals with disabilities, something not previously faced by the welfare community.

States' policies also vary with respect to caregiver's participation in welfare-to-work activities. Many caregivers do not have personal limitations that affect their ability to work. However, their ability to work or participate in employment-related activities required by the welfare system is limited due to obligations to care for an ill or incapacitated family member. This study found that most States [42 of the 48 states] apply the same participation policy to caregivers as is applied to individuals with disabilities. States with broader participation policies are taking a harder look at the situations of caregivers to determine their ability to participate, such as determining whether the disabled individual in the household is in need of full-time care or if alternative care arrangements can be made. A majority of the states have adopted the same time limit policies for caregivers as for individuals with disabilities.

Regardless of the policy approaches currently in effect in a particular State, the report concludes, States are overwhelmingly interested in learning about and developing policies and effective program strategies for persons with disabilities (and the hard-to-serve in general) as they continue to struggle to reduce welfare dependency. States that choose to address the specific needs of individuals with disabilities and caregivers will likely have to alter the infrastructure that supports their current approach to welfare provision, an investment that may require additional resources.

This study was conducted by The Urban Institute for the Office of the Assistant Secretary for Planning and Evaluation (ASPE). The project officer, William Marton, can be reached at 202-690-6443. Copies of the final report, #7245, are available from the PIC.

Evaluation of Encarguese De Su Diabetes: Una Guia Para Su Cuidado

A preliminary diabetes patient guide targeted to Hispanic populations was produced by the Division of Diabetes Translation (DDT) of the National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention. The purpose of the guide is to provide information to Hispanics with diabetes on how to take care of and control their disease. Prior to widespread dissemination, DDT sought a contractor to evaluate the Guide. The evaluation results were used to produce a Guide that would be culturally-relevant, readable and comprehensible for those with at least a sixth grade level of education. The Guide would provide information on diabetes complications and self-care management. The evaluation contract also called for the production of a video concept paper and a Spanish language script.

The objectives were to identify the types of health information needed to enhance the day-to-day management of diabetes and to determine additional appropriate methods for communicating information on diabetes self-care.

The evaluation was conducted through focus group discussions (FGDs) in two phases, from March 1994 to August 1994. The CDC-approved states and locations were California (San Diego); Florida (Miami); Illinois (Chicago); Texas (Houston) and Washington (Toppenish). Hispanic populations representing Mexican Americans,

Central Americans, South Americans, Cuban Americans, and Puerto Ricans comprised the focus group participants. Local providers associated with state control programs volunteered to serve as site coordinators and assisted in identifying and selecting focus group participants and sites. A topic guide was developed as a tool to elicit participant perspectives about the Guide and additional methods for communicating and disseminating diabetes information.

The first phase of the FGDs was to evaluate the preliminary Guide produced by CDC. The second phase evaluated the revised Guide based on suggestions and additions made by participants and concentrated on eliciting perspectives on additional methods for communicating information on diabetes self-care. Results from Phase I FGDs related to enhancing the clarity and adding information to the contents of the Guide, for example, they suggested changing the title of the Guide to convey the message that diabetes can be controlled. Extensive additions and revisions made to the Guide from the Phase I FGDs led to only minor changes for the Phase II Guide.

A video concept paper and video script were developed based on feedback during the FGDs, which were the result of the media-related findings. These findings indicated a need for a multimedia approach to diabetes information dissemination. Participants expressed desires to be able to access Spanish language materials in print, audiovisual, and audio forms. Diabetes messages, according to the informants, should be presented in both English and Spanish to accommodate varying levels of acculturation to American society. The media materials should also be developed that target Hispanic populations who read at less than a sixth grade level of education.

This study was conducted by Casals and Associates for the Division of Diabetes Translation (DDT) of the National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention (CDC). The

project officer, Patricia Mitchell, can be reached at 770-488-5015. Copies of the final report, #5352, are available from the PIC.

Strengthening Minority Health Data Collection

One of the objectives of *Healthy People 2000* was to increase to at least 50% the proportion of counties that have established culturally and linguistically appropriate community health promotion programs for racial and ethnic minority populations. Baseline data to meet this objective have been unavailable to date due to definitional problems with “culturally and linguistically appropriate community health promotion programs” and the lack of a data source. This study, completed in 1998, is the result of a cooperative agreement between the Centers for Disease Control and Prevention (CDC), the National Association of County and City Health Officials (NACCHO) and the Office of Minority Health, Department of Health and Human Services. The purpose of the study was to collect information on minority health issues and culturally appropriate services, with these objectives: 1) to measure the percentage of local health departments that meet their community’s health needs through linguistically appropriate and culturally sensitive interventions as outlined in *Healthy People 2000*, Objective 8.11; 2) to establish baseline measures, where needed, for *Healthy People 2000*, Objective 8.11; and 3) to address related public health issues when applicable and appropriate.

It should be noted that *Healthy People 2000* has been replaced by *Healthy People 2010* and objective 8.11 has been replaced in the *Healthy People 2010* initiative by objective 7.11. The baseline data collected from this study is now incorporated into the corresponding objective in *Healthy People 2010*.

The project supported efforts by NACCHO to include in their regularly conducted stratified sample surveys of local health departments (LHDs) questionnaire items that would provide data that can be used as a proxy baseline for this objective. Key informant interview data about the needs of minority health agencies was collected from representatives of 47 minority health agencies and organizations. This data was used to formulate a set of questions to develop a comprehensive survey of local health departments' services and demographic characteristics. The NACCHO survey was sent to a random sample of LHDs serving communities with 10 percent or more racial/ethnic minority populations.

The baseline data gathered from this research indicates most local health departments are engaged in some sort of culturally sensitive and linguistically appropriate intervention in the areas of health promotion and preventive services. In the area of health protection, 43% of health departments reported at least one linguistically appropriate intervention and 35% reported a culturally sensitive intervention. However, these culturally and linguistically appropriate interventions do not necessarily constitute formal, structured "community health promotion programs" and fall below the 50 percent target set in the Healthy People objective. This study provides the baseline to measure the objectives and sets the stage for additional contextual research to be conducted on the provision of cultural and linguistic services to racially and ethnically diverse populations.

This study was conducted by the National Association of County and City Health Officials (NACCHO) for the Centers for Disease Control and Prevention (CDC) in cooperation with the Office of Minority Health, Department of Health and Human Services. The project officer, Guadalupe Pacheco, can be reached at 301-443-5084. Copies of the final report, #6798, are available from the PIC.

Background Research and Recommendations for the Food Safety Campaign

This report presents a compendium of evaluations of recent food safety education programs, recent consumer surveys and qualitative consumer research related to food safety issues, epidemiological data on the magnitude and distribution of foodborne illness in the United States, and microbiological/risk assessment analyses of food consumption, handling, and preparation practices that increase or decrease the likelihood of foodborne illness. The report considers information obtained from meetings with experts identifying critical objectives, presents a comprehensive summary of the qualitative and quantitative research on food safety issues, identifies the information needs for developing a strategic approach to consumer education, and summarizes the results of focus groups conducted to meet those needs. Finally, the report encapsulates expert opinions on designing education programs and communication strategies to change food-handling behavior and presents proposals for developing a successful consumer food safety campaign.

Some important messages tested during the focus groups conducted on behalf of the FDA in 1998 were:

- Today's bacteria are more deadly, more resistant, and more widespread than ever before. That's why people today have to do more to protect themselves and their families.
- Food poisoning occurs most often and most seriously in young children. Extra precautions should be taken in preparing food for children under 5.
- 98% of homes tested by a health inspector failed the test given to restaurants.

- Bacteria can enter food at any point from the farm to the processing plant to the grocery store. If any one of these places makes a mistake, bacteria can enter your kitchen.
- 80% of chicken entering the home is contaminated with salmonella or campylobacter.

The report recommends an FDA Food Safety Campaign that empowers consumers with science-based food safety information that targets, in particular, mothers of small children under age five and elderly people, or those who prepare food for them.

This study was conducted by Sutton Social Marketing for the Food and Drug Administration. The project officer, Alan Levy, can be reached at 202-205-9448. Copies of the final report, #7275, are available from the PIC.

Mandatory Managed Care: Children's Access to Medicaid Mental Health Services

This report describes access to Medicaid mental health services under mandatory managed care for children with serious emotional disturbances. The investigation by the Office of Evaluation and Inspections (OEI), within the Office of Inspector General (OIG), was not conducted to specifically focus on children. However, while completing their inspection on "Mandatory Managed Care: Changes in Medicaid Mental Health Services," specific problems with children's access to care were observed.

A case study approach was used to review mandatory mental health managed care programs in seven states to integrate, compare and summarize documentary and testimonial evidence from State Medicaid managed care offices and mental health departments. Interviews were conducted with managed care organization of-

ficials, mental health providers and stakeholders for children's mental health.

Children are eligible for Medicaid benefits if they are under the age of 21 and their families' income is low. Most states will extend eligibility to children who have qualified for the Supplemental Security Income Children's Program. Children who qualify for Medicaid up to age 18 as seriously mentally disturbed, are those who currently or any time in the past year have had a diagnosable mental, behavioral, or emotional disorder that results in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

The five states initially selected for the study had been under a mandatory managed care program for persons with serious mental illnesses for at least three years. They were Arizona, Massachusetts, North Carolina, Utah, and Washington. The States of Iowa and Colorado were added by the Health Care Financing Administration (HCFA) because of their innovative programs. All the states, except North Carolina, included both adults and children in their mandatory managed care mental health contracts.

The findings indicate that: access to care for children's mental health care is limited; first year managed care contracts include limited provisions for children; reductions of in-patient care for children is greater than that for adults, and; responsibility for the care of these children is fragmented. Placing mental health services under a capitated (flat fee) payment arrangement can potentially increase the incentive for managed care organizations to shift care to other state agencies, such as juvenile justice, child welfare, or the education system, to reduce costs. The report indicates that because of the complexity of needs of children with serious emotional disturbances, a variety of State and Federal programs could be called upon to provide services to these children. The problem is that each program has its own budget and priorities and they work independently of each

other, thereby causing a fragmented system of care for children.

The report recommends that HCFA encourage States to provide more detailed specifications on services managed care organizations will provide, to help ensure children receive the specialized care they require. Also, establishing interagency agreements could ensure better coordination of care and improved services for children, and may reduce cost shifting concerns among agencies.

This report was prepared by the Office of Inspector General of the Department of Health and Human Services. Copies of the Final Report, #7282.2, are available from the Policy Information Center.

Medicaid and Special Education: Coordination of Services for Children with Disabilities Is Evolving

The Individuals with Disabilities Education Act (IDEA) has authorizing legislation and regulations that requires coordination with other federal programs, such as Medicaid, to finance and deliver services to children with disabilities. Because the boundaries between the two programs are unclear, this study was conducted to (1) describe how Medicaid and IDEA interact to meet the needs of low-income school-aged children with disabilities and (2) identify issues that have arisen in coordinating Medicaid and IDEA services in schools.

Federal and state officials, and a few local school district officials were contacted regarding the coordination mechanisms used by IDEA that are relevant to Medicaid activities in schools. On the federal level, the Health Care Financing Administration (HCFA), which has oversight for the

Medicaid program, and the Department of Education staff involved in coordinating IDEA with Medicaid, were contacted. On the state level, 12 states were contacted, nine of which are among the states with the highest number of school-aged children in special education and three that had predominantly rural populations.

The results indicate both programs (Medicaid and IDEA) interact differently at the federal, state, and local levels. Federal efforts relative to both programs focus on assisting states to access funding sources such as Medicaid, and developing clear and consistent guidance to help educational entities appropriately claim Medicaid funding for IDEA-related medical services. For the 12 states contacted, interagency agreements and agency liaisons are the primary mechanisms of state-level interaction between Medicaid and IDEA. Coordination difficulties at the state and local level revolve around achieving clarity on what services Medicaid will pay for, determining Medicaid eligibility for children with Individual Education Programs (IEPs), and establishing clear methods of documentation for billing Medicaid. Coordinating these activities between educational entities and Medicaid programs has been hampered by the lack of clear and consistent federal guidance.

The recommendation is for more clear and consistent federal guidance that will assist states and local communities in communicating Medicaid's coverage and documentation requirements. Recognizing the need, HCFA will develop additional guidelines, with distribution expected during the year 2000.

This report was prepared by the General Accounting Office. Copies of the Final Report, #7258, are available from the Policy Information Center.

RECENTLY ACQUIRED REPORTS

- The Effects of Education and Information Source on Consumer Awareness of Diet-Disease Relationships, PHS-FDA, (PIC ID No. 7238)
- Positive Youth Development in the United States: Research Findings on Evaluations of Positive Youth Development Programs, OS-ASPE, (PIC ID No. 6878)
- A Guide to Assessing Linkages Between Comprehensive HIV Prevention Plans and HIV Prevention Programs, PHS-CDC, (PIC ID No. 7281)
- Infant Mortality Prevention in American Indian Communities: Northern Plains Healthy Start, PHS-HRSA, (PIC ID No. 5610.2)

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